Transcript of Proceedings

THE HONOURABLE G DAVIES AO, Commissioner

MR D C ANDREWS SC, Counsel Assisting
MR R DOUGLAS SC, Counsel Assisting
MR E MORZONE, Counsel Assisting
MR D ATKINSON, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 2) 2005

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

BRISBANE

..DATE 03/10/2005

..DAY 16

4th Floor, The Law Courts, George Street, Brisbane, Q. 4000 Telephone: (07) 3247 4360 Fax: (07) 3247 5532

THE COMMISSION RESUMED AT 10.00 A.M.

COMMISSIONER: Before you start, Mr Andrews, I was asked by one of the parties, through Mr Andrews, of counsel, two questions: one was whether I intended to receive oral submissions as well as written submissions. The answer is no. If any of you think that you need to make oral submissions in addition to written submissions, then I suggest - and I have put this in the direction I have given - that you include a submission to that effect in your written submission, but I indicate now that unless there is some special reason for it, that is not being able to make the submission in your written submissions, I don't intend to receive oral submissions.

The other question I was asked was whether I intended to make preliminary findings and the answer is no. Yes, Mr Andrews?

MR ALLEN: Excuse me, Commissioner.

COMMISSIONER: Yes.

MR ALLEN: In relation to Dr Nothling this afternoon, it doesn't appear from the face of his report that at that time he had access to the interview of Mr Leck with Commission staff. In my submission, it would be helpful if he at least had access to the transcript before he started his evidence this afternoon.

COMMISSIONER: There was some question about the accuracy of that. Mr Leck's counsel is not here.

MR ALLEN: Or at the best, if there was time, if he had access to the actual recording, but as far as I can see the transcript would be helpful. Where there seems to have been matters which can't be discerned, then noted.

COMMISSIONER: That sounds correct to me. Does anybody have any other views? All right, can we do that?

MR ANDREWS: Yes, I can arrange to have the transcript forwarded to Dr Nothling. I understand that Dr Nothling was available this afternoon because he had patients this morning.

COMMISSIONER: That might be a problem. How long is the transcript?

MR BODDICE: About 67 pages.

COMMISSIONER: Oh, dear. That might pose a problem.

MR ALLEN: It may not be possible but I was just raising that if he did have time. The other matter was whether or not before Dr Keating gives evidence the interested parties can expect to have a statement from him at a reasonable time before that begins.

COMMISSIONER: Yes, I don't know whether - do we have a statement from Dr Keating?

MR ANDREWS: No, Commissioner.

COMMISSIONER: All right.

COMMISSIONER: We will supply it when we get it. Yes.

MR ANDREWS: Before calling Dr Crawford, Commissioner, I anticipate that a five patients' names will be a topic of examination and cross-examination. I ask for an order that their names be suppressed. They have not yet been contacted with a view to obtaining their consent to disclosure.

COMMISSIONER: I so order now. Yes?

MR ANDREWS: I call Dr Crawford.

SCOTT ANDREW CRAWFORD, SWORN AND EXAMINED:

MR ANDREWS: Good morning, doctor. You are Scott Andrew Crawford?-- That's right, yes.

Doctor, you prepared a statement and swore it on the 16th of September 2005?-- That's right, yes.

Do you have a copy of it?-- I do.

Are the facts recited in it correct to the best of your knowledge?-- They are, yeah.

Where you express opinions in it, are they honestly held by you?-- They are, yes.

I tender a copy of that statement.

COMMISSIONER: That will be Exhibit 404.

ADMITTED AND MARKED "EXHIBIT 404"

MR ANDREWS: Doctor, you are the Director of Orthopaedics at the Prince Charles Hospital at Chermside?-- That's right, I am, yeah.

Are you a practising clinician when you practise at Prince Charles?-- Most of my work there is clinical work, and probably about a quarter to a third of it is administrative.

You have a fellowship in orthopaedic surgery?-- That's right,

yes, I do.

Doctor, you have been attending at the Hervey Bay Hospital as a result of efforts made by Queensland Health, following the publication of what's known as the North Giblin Report?-- I have. Queensland Health set up a system whereby people could go up there and the Queensland branch of the Australian Orthopaedic Association also sent out a memo to all their members advising them and asking them for assistance.

Now, that occurred after the publication of the North Giblin Report, is that correct?-- Well, I got that memo on 25th of May this year, so.

Are you aware of any occasions when the - when Queensland Health has established a patient liaison service to attend to concerns raised with respect to clinical services performed generally at any particular hospital, apart from, for instance, Hervey Bay and Bundaberg Base Hospital?-- There are patient liaison officers who do similar sorts of duties in probably most public hospitals. I am not aware of specific people who are dedicated for this type of thing in the way it has been here, but certainly there are people who do fulfil this type of job as part of the routine, ongoing, day-to-day running of the hospital.

So that I can understand that answer better, let me put it in my words. Do you mean that there are patient liaison officers in certain hospitals being persons with whom patients can liaise?-- With any difficulties they have with the service, or accessing the service, or really just to make things flow more smoothly.

But with respect to the response of Queensland Health to concerns raised in the North Giblin Report, being the establishment of a patient liaison service, a hotline telephone number, and the, I suppose, funding and organisation of a number of orthopaedic specialists to attend at Hervey Bay, that is unique, in your experience?-- I don't recall anything similar to the model you are talking about, no. I have only seen what's been set up at Hervey Bay. I haven't seen exactly how the model is at Bundaberg. I have only seen what I have seen through the media there, so.

Is it reasonable to conclude that this has happened, that is this unique response, has happened because there was publication of the North Giblin Report, or do you think this response may have occurred whether the report had remained unpublished?-- I would hope that if Queensland Health became aware of any, you know, problematic situation, that they would set up a response, whether or not there was a public report. I mean, I am not involved in Queensland Health corporate office at all, but, I mean, I would hope this is how they would respond to any situation.

COMMISSIONER: We would all hope that, doctor. It just hasn't happened?-- Sorry?

It just hasn't happened?-- Mmm.

MR ANDREWS: You are agreeing that it doesn't seem to have happened before?-- No, no, not that I am aware of.

During your visits, you have seen a total of 90 patients?-- I believe it is about that number, yes.

They have included patients who have contacted the hospital via the hotline requesting a review of the treatment that they had had in the orthopaedic department?-- That's right, yes, yes.

But there were also others who hadn't been treated who were simply on the elective surgical waiting list?-- Well, some who had already been seen and been booked for surgery, but who, because of the situation up there, didn't have their surgery carried out there.

And there was a third group, patients you were requested to review by either Dr Sharma, Dr Krishna or Dr Padayachey?-- That's right, yes.

Of the patients who made contact via the hotline for a review of treatment that they had already had, it was only about 40 of the 90 that you have reviewed, is that the case?-- I believe it was about that number, yes.

And you have made particular mention of five of them in your statement where you say the outcome wasn't satisfactory?-- Yes. When the investigator of the commission came to ask for a statement, he was particularly interested in any patients who I thought the treatment hadn't been optimal, and these were the five I could identify who - I mean, there were some other patients who had bad outcomes which were just more the nature of their injury, or who had problems which weren't necessarily related to what was done but may have happened otherwise, and there were some who seemed to be going very well.

Yes.

COMMISSIONER: Of some of those in the doubtful category, they could have been the cause of faulty surgery but you couldn't say that one way or the other positively?-- Some I could say were definitely more predictable outcomes from the injury. They have had people who had fractures around the wrist, who have some persisting stiffness which is, you know, common in older people. Similar with injuries around the elbow and shoulder. I saw a number of patients who had had joint replacements where something may have been becoming loose, but, I mean, that happens in a proportion wherever they are done and there was nothing that I saw that particularly said that it was badly done surgery.

All right, thanks.

MR ANDREWS: Doctor, I am interested in pursuing this topic:

if I set aside the five that I will ask you to deal with shortly, I am left with 35 of about 40?-- Yes, you are.

And some were done well?-- Mmm.

Some had poor outcomes but you would expect poor outcomes in a group of that number in any event, is that the case?-- Well, yes, but poor outcomes are also a relative thing. I mean, some of the ones I saw may have been functioning well but just had some persisting stiffness and just wanted to be seen to see if there was anything else that could be done.

With respect to that group of poor outcomes in the balance of 35-----?-- Yes, yeah.

-----is it your opinion that you are unable, from the examination you had, to conclude whether the surgery was performed with reasonable care or to a lesser standard?-- All the evidence I saw was that it was performed with reasonable care, mmm.

Thank you. Now, the five patients who you deal with in your statement were each patients who had had elective surgery?-- Four had had elective surgery. One, the fifth one mentioned, had had surgery after a fracture.

Was that a football injury?-- I don't recall the mechanism.

I will take you to it shortly. The significance of elective surgery is that the treating doctor has the opportunity or the choice to refer the patient elsewhere?-- That's right, yes.

And so if elective surgery is to be performed and a doctor is concerned that he or she mightn't have the skills to perform that elective surgery, it is appropriate then to advise the patient and consider referral either to another doctor or another place?-- Definitely, and that does happen quite a lot.

And so it is not good medicine for a person in an orthopaedic department to say, "I will do it anyway"; it is appropriate performance of one's clinical duties to advise a patient and refer the patient elsewhere if one is concerned that one hasn't got the skills?-- That's right, yeah, and in the snapshot I have seen of the work I have done up there, I haven't been in a position to see whether that did happen regularly through Hervey Bay or not.

The first patient you discuss in your statement at paragraph 14 is a - is P442? -- Yes.

I have the advantage of a report that you dictated on the 2nd of June with respect to that patient. Do you have a copy of that report with you?-- I do, yes.

Are the facts recited in it true to the best of your knowledge?-- Yes.

And the opinions expressed in it honestly held by you?-- They are, yes.

I tender a copy - I will tender a copy of that report. First I think I will put it on the monitor, Commissioner. It is the case that P442 was operated on for elective foot surgery?-- It is, yes.

And you recall from the notes that the procedure was performed by Dr Krishna?-- That's right, yes.

That's from the hospital notes?-- Yes.

I will ask that this be placed on the monitor. Is that the operation report dated the 28th of January 2004, and does it show the surgeon's assistant to be D Krishna?-- That's correct, yes.

Thank you. That's all I need of that document. Now, what is it about P442 procedure that concerns you?-- Well, this was-----

Is there something on that document that's highlighted in yellow?-- This was the - only one of the cases I have quoted where I believe it was - the procedure that was performed was actually wrong, rather than necessarily how it was performed. The aim of the operation is to stiffen one row of joints in the toes and to excise a second row and leave them floppy, which would be a standard procedure, and that's what the patient was booked for. So the patient was actually booked for appropriate surgery, but when the operation was performed, the patient actually had two rows of joints stiffened, rather than just one, which was, I think, clearly the cause of his ongoing pain and symptoms. He did subsequently have corrective surgery which I performed in Maryborough to excise one of the rows of joints that had been stiffened, which basically put him back to the situation he would have been if he had had the original surgery. So I think his final outcome was the same as it would have been but the actual - what was actually done at the first operation wasn't really an operation that would be generally done. In fact, I am not aware of it being a described operation, to actually stiffen both rows of joints.

I see. I may have to discuss this with Dr Krishna?-- Sure.

Which was the row of joints which ought to have been stiffened?-- The joints called the MTP joints, are the ones which were stiffened but I thought shouldn't have been. The ones called the PIP joints were the ones which were to be stiffened and were done correctly.

In the highlighted section from your report, which appears on the monitor-----?-- That's right, yes.

-----you note the decision to fuse the MTP joints but you speak of a second decision, that is "to only resect the second and fourth metatarsal head." Was that a poor decision also?--

It was. Generally the problem-----

Is that a different topic from the-----?-- No, it is all part of the same - it is the same joints, and the aim of the operation or what would generally be carried out is to actually take out the bone from underneath four of the - the four lesser toes, whereas this has only been done to two of those and those joints stiffened. Generally, if it is not done to all four at the same time, then that causes pressure on the other ones. So it is all part of the same-----

COMMISSIONER: But it is an additional problem with the way that operation was performed?-- It is, yes.

MR ANDREWS: If an orthopaedic surgeon had been supervising Dr Krishna and supervising in a reasonable fashion, is this something that such a surgeon might have permitted Dr Krishna to do?-- I don't believe so, no. As I say, I am not aware of this being a described procedure and I have gone and looked up to see if it is described just to double check on that.

Dr Krishna is not an orthopaedic specialist. Is this a procedure that he ought to have been permitted to do without supervision?-- I haven't seen enough of his - of a spectrum of his practice.

I don't mean the errant procedure; I mean the procedure that was booked?-- I haven't really seen enough of his - you know, the scope of his practice to know what his level of competence is.

How much seeing of the scope of his practice would you need to have before you certified to the level of his scope of practice?-- Well, certainly want to see him perform a number of - a number of operations of foot surgery before I certified this. The procedure isn't a particularly uncommon one, or the procedure that was planned, so it is something that, you know, would come up relatively regularly in a standard practice, standard general orthopaedic practice, and it is a procedure that could well be carried out by a trainee without a consultant present. But certainly someone with at least a moderate level of experience, but I haven't seen enough to say whether Dr Krishna has that level of experience or not.

Well-----

COMMISSIONER: This operation would suggest that he hasn't, wouldn't it?-- Certainly the judgment as to what to do was wrong in this case, very much so.

MR ANDREWS: Well, I tender the report relating to P442.

COMMISSIONER: That seemed to have two dates on it, a dictation date and a typed date. It hasn't been signed. How do I identify it?

MR ANDREWS: It may even have a checked date.

COMMISSIONER: Does it?

MR ANDREWS: On the second page. Doctor-----

COMMISSIONER: Yes, I see that, 10 June.

WITNESS: Typically what happens with - certainly at the hospital - I am not - I don't know if it is the same at Hervey Bay - a letter would be signed and that letter would go to the general practitioner or whoever the letter was dictated to.

COMMISSIONER: I just want to know what's the appropriate date of this letter, doctor, if you can just tell me that?-- Well, I certainly saw P442 on the 2nd of June and dictated-----

Just so far as you were concerned, when was this letter finalised in this form?-- On the-----

The 2nd, the 9th, or the 10th?-- It was typed on the 9th and checked by me on the 10th.

I see, so it is the 10th of June?-- Yes.

All right. I will mark that report, dated the 10th of June, Exhibit 405.

ADMITTED AND MARKED "EXHIBIT 405"

MR ANDREWS: I would like you to look on the monitor at the second and third page of Exhibit 313, which is the scope of practice document relating to Dr Krishna for elective surgery. Actually, the third and fourth page. The third page should be headed "elective surgery" - "elective orthopaedic surgery", yes?-- Uh-huh.

You can accept from me that the column that contains ticks under the heading "performed independently"-----?-- Yes.

-----are to designate the procedures that Dr Krishna, according to his scope of service, was entitled to do without supervision?-- Yes.

Rotator cuff tendonitis and rupture simple, with the operation described to its right?-- Mmm.

Would you need to have observed - tell me how many times would you have needed to observe the doctor before you certified his fitness to perform that independently?-- I would probably want to have seen him perform at least half a dozen operations with assistance to be sure that he was, you know, functioning at a good level to do straightforward surgery of this type. Something more complex - I don't actually do any of this type of surgery any more, rotator cuff surgery.

The next item seems to be CTS and the operation CTD, synovectomy?-- That's right, yeah.

How many occasions would you need to observe?-- Relatively small number, possibly only two or three. It is an operation which is very common and I believe is also carried out by general surgeons, sometimes general practitioners in rural areas. It is not a particularly complex procedure.

The next item - can you pronounce it for me?-- It is called Dupuytren's contraction which is the name of the person who first described it.

How many of those would you need to observe before certifying?-- Probably quite a few. Again, it is a type of surgery that I no longer do. I mean, it is - it covers a whole spectrum of relatively straightforward to very complex surgery, depending on how advanced the disease is, but it is certainly not a particularly simple procedure.

The next ganglion bursar Baker's cyst?-- Relatively small number, possibly three or four.

Trigger finger?-- The same.

Well, I have attempted to highlight ones that I think have been performed by one doctor or another?-- Yes.

The MTPJ arthrodesis?-- Yes.

Is that a procedure that was performed on one of these five patients?-- Two of the five.

And how many of these procedures would you have wished to have observed before certifying a doctor to do these without supervision?-- In isolation, probably half a dozen, but if someone who you're observing a lot of similar surgery, other types of bunion surgery in the same area, then probably a lesser number. I mean, if you had seen them do a lot of surgery around the similar region, maybe two, three, four would be enough in addition.

The next one hammer toes arthrodesis?-- Yes.

Am I correct that's another procedure you comment upon?-- That is, that's part of the procedure P442 had that was booked and that was done appropriately.

Am I right in recalling you believed you ought to have observed about half a dozen of such procedures before certifying?-- Probably about that, yes, that would be a reasonable number, mmm.

The five of 40 procedures-----?-- Mmm.

-----that you feel showed poor outcomes which in your opinion are attributable to a failure to take reasonable care, now am I putting words in your mouth appropriately with that question?-- Probably not. They're all quite different type of cases. I mean, two of them it was more just - the correct procedure was done and achieved what was set out to do, just the position the joint was put into was not quite right and had to be corrected, which is more a - you know, a judgment rather than a failure to take care.

Are you able to say whether the statistical result of five out of 40-----?-- Mmm.

-----is an alarming proportion?-- Well, not at all because those 40 people were selective people who'd come through the hotline. Not all of them had actually had surgery, not all of the ones who'd had surgery had had it done by these doctors or necessarily even done at Hervey Bay hospital. So the 40-----

Well, if not of-----?-- The 40 isn't a randomly selected group of their practice. It is a particular bunch of patients who have come with concerns.

If not all of them had had surgery and if not all of them had had surgery by these doctors?-- Mmm.

Doesn't it suggest that you're looking at a sample that's less than 40?-- Of those who've had procedures done at Hervey Bay, who have then come through the hotline and come up complaining of - with concerns, mmm. But that is a very selected group.

I understand?-- Mmm. I'm not sure I can apply statistics to that sort of thing.

Thank you. The next patient you discuss in the statement is described as P443. It's P443, isn't it?-- That's right, yes.

P443 is described by you as a person who has had a procedure performed by Dr Krishna. Let me identify the - from the hospital notes, the operation report - would you look at this document on the monitor?-- Mmm-hmm.

Is that the procedure-----?-- That's right, yes.

-----that relates to P443? -- It is.

Do you see the name of the surgeon's assistant seems to be - does it look like "D Sharma"?-- It does. Yes, it is.

Is it possible that you were mistaken as to the name of the surgeon who performed this procedure?-- I'd have to check what I actually put in my letter on that. When you say mistaken, I'm not sure that-----

Well, that you have-----?-- Where I have stated something else. It's possible I'd be mistaken but I'm not sure where you're referring to.

I inferred from paragraph 16 of your statement in the last sentence that-----?-- That is incorrect, yes.

COMMISSIONER: Which is incorrect?-- In the paragraph 16 I've mentioned that the three patient - three other patients were operated on by Dr Krishna. P443 was operated on by Dr Sharma.

Thank you?-- Mmm.

MR ANDREWS: You've prepared a statement - I beg your pardon, you've done three brief reports, at least with respect to P443, and you've received one from Dr Peter Rowan; is that the case?-- That's right. The three reports, one was a letter to her general practitioner, one was a letter to Dr Rowan, who is a hand surgeon at Royal Brisbane Hospital, asking him if he'd review her, and one was to the outpatient department at Royal Brisbane Hospital about an appointment. I did get a letter back from Dr Rowan but I don't have a copy of that with me.

I'll put a copy of Dr Rowan's on the screen. Is this the letter written to you by Dr Rowan?-- It is, yes.

Dated the 11th of August 2005?-- That's right. Yes.

Are the observations made by Dr Rowan that P443 still has a fair degree of pain and stiffness and her scars had formed keloid and, indeed, all the observations within that report are consistent with things you'd observed and with your

opinions?-- They are, yes.

Are your reports with respect to this patient a signed report of the 24th of June to Dr Ogunseye - O-G-U-N-S-E-Y-E - and I suppose a second report unsigned to Dr Ogunseye dictated on the 7th of September 2005?-- Yes.

Commissioner, I will tender those three reports or copies of them. Are the facts recited in your own report true to the best of your knowledge?-- You're talking about the dictated letters you just mentioned?

Yes, your reports to Dr Ogunseye?-- That's right, they are, yep.

And your opinions are honestly held by you?-- I'm just trying to see if I actually expressed much of an opinion. I don't think I really commented on her treatment; really just mentioned to Dr Rowan that she was having ongoing problems and asked if he'd take over her care.

Yes. Doctor, could you tell me, please, what is it about the treatment of P443 which is noteworthy?-- I think the main problem with her treatment was that when this type of procedure is done, it's usually done on the front of the fingers and it's an area which is notoriously bad for scarring and the incisions have to be done in a certain way and usually a sort of more extensive way which avoids scarring and the later complications of scarring. I think this wasn't done in her situation and she did subsequently have problems with scars contracting on the front of the finger which has created stiffness, and it is a well recognised thing that happens in this area if the incisions aren't made in the correct position.

You've spoken of incisions being made in a more extensive way?-- Yes.

And incisions being placed in the correct position?-- Yes, yes.

Are they two different features that ought to have been-----?-- Well, they're actually the same thing. That it's possible to do the operation through a very straight incision which is the smallest incision possible but that then leads to further problems where that scar will contract and cause trouble. So, in fact, the more extensive operation actually causes less trouble later on.

And the less extensive operation?-- Mmm.

Which I gather was the one performed by Dr Sharma here?-- That's right, yeah.

Was that an error that an orthopaedic specialist acting reasonably would not have made?-- I'd have to say it was. When we talk about performing the operation, there's two aspects. There's the - what incisions are actually made in

the skin and I think that's where the problem with this lie. Then there's what's actually done underneath and I think as far as I can tell, I can't be certain because she has got the stiffness, but what was done underneath may well have been done correctly. But it was the management of the skin that was the issue here, which has created the subsequent problems. But it's something that for this to be done the way it was, an orthopaedic specialist I wouldn't expect to perform it in that manner.

And is this something that an orthopaedic specialist might anticipate as a failure that might commonly be made by an unsupervised PHO?-- Probably - well, whoever was performing the surgery should have a good idea of the way to go about it. It's not necessarily a lack of technical ability that's done it, it's more the planning of the surgery. So it's certainly - this isn't the type of surgery which I would leave someone to do unsupervised unless I was quite happy with their competence and, in fact, because it can be quite complex, I no longer perform any of this type of surgery either but most of it I refer on to Dr Rowan or someone - someone similar. Having said that, it is appropriate surgery to be performed by generalists but, yeah, it can be quite complex. It's certainly not something you would usually leave someone very junior to do unless you were quite certain about their ability with it.

I tender those three reports that I described, Commissioner.

COMMISSIONER: All right. I will make all those Exhibit 406.

ADMITTED AND MARKED "EXHIBIT 406"

COMMISSIONER: You can hand them up later if you like.

MR ANDREWS: Thank you, Commissioner. The next patient you discuss is P444?-- Yes, yes.

Who had foot surgery by Dr Krishna. And in respect of P444, you have done a one-page report to Dr Goldston?-- I have, yes.

Checked on the 10th of June 2005?-- That's right, mmm.

Are the facts recited in it and the opinions in it true to the best of your knowledge and honestly held by you?-- They are as far as I can say. There is one area where I also quote the patient's opinion of an aspect, the cancellation of treatment, as I have quoted there, but as far as my own opinions, yes.

Thank you. Would you look at this document on the screen, please. You can ignore my handwriting?-- Sure.

It seems that this patient had two procedures, a first MTP

fusion on the 3rd of September?-- Yes, yes.

And a subsequent procedure, am I correct? Perhaps I'm confusing her with another?-- No, I think one of the issues that the patient raised here initially was that she came in for - to have a procedure and it was cancelled at the last minute for reasons which weren't well explained. That was one of the concerns she raised. As far as I recall, she only had one procedure done prior to my seeing her on this occasion.

And I deduce from the second paragraph that opinions may have differed on whether fusion was a reasonable option but on balance you've deduced that it was?-- As far as I could tell with the information I had then, I think the procedure that was actually planned for and done was reasonable, yes.

Are you able to identify on that page anywhere where you describe an error in either the choice of procedure or the manner of its execution?-- The - what the procedure is is to stiffen a particular joint in the toe. The important thing as far as the clinical outcome - firstly, whether the joint stiffens and in fact it did in this case, which was planned for, but the position which it fuses is the most critical aspect and if that's not quite right, then people will often have ongoing pain, pain or difficulty with footwear or walking, et cetera. I believe that the position that was achieved, the joint was appropriately stiffened but just not quite in the right position.

And is the position indicative of a lack of reasonable care by the surgeon performing the procedure?-- It can be a difficult judgment to make but it's important to get it as good as you can.

And-----

COMMISSIONER: An orthopaedic surgeon would ordinarily - would usually have done it better than this?-- Generally would, and most - in most cases it would happen. It's the sort of case,if you saw that someone who is competent had done this and had achieved the same result, I mean, it wouldn't ring any alarm bells but you'd say, "Well, they didn't get it right."

I see?-- It is not particularly the sort of case which, you know, screams of incompetence in itself.

Okay.

MR ANDREWS: Do you mean that in your opinion this was a case that if supervised you'd expect would be likely to have had a better result?-- Likely to, mmm.

Was this a case where it would have been proper for an orthopaedic specialist to have supervised Dr Krishna?-- I suppose again I come back to the point that I'm not really aware of Dr Krishna's technical abilities. I haven't seen a broad aspect of his work so I don't know whether it is

something he should or shouldn't be doing himself. I have never been in theatre with him and I've only seen the particular patients with the concerns. I don't know how many procedures he's done that have gone well or not gone well.

Had this patient had a subsequent proceed procedure?-- He has. I have subsequently done surgery on her in Maryborough which in the short term seems to have achieved a good result.

The next patient you refer to is P445, again a patient who had foot surgery?-- That's right, it was essentially the same procedure was done.

Commissioner, I tender that last report of Dr Crawford.

COMMISSIONER: Thank you. That will be Exhibit 407.

ADMITTED AND MARKED "EXHIBIT 407"

MR ANDREWS: I will use a clean copy as the exhibit I think rather than the one that has got my own handwriting upon it.

COMMISSIONER: All right. Okay. I will give that back to you.

MR ANDREWS: Thank you. Would you look at, please, the monitor where I hope to display a report of yours relating to P445, checked on the 10th of June 2005. Do you recognise that as your report?-- Yes, I do.

And the facts stated in it are correct to the best of your knowledge?-- They are, yes.

Any opinions you state in it would be honestly held by you?-- Yes, mmm.

What is it about P445's - P445 is a patient who had two treatments; am I correct?-- She did. She had the same procedure as the one we discussed on the previous patient. She's had it performed on each of her feet. On one side, on the left side, she got a very good result and everything seems to have been done completely appropriately. On the right side she had the same problem as the previous patient mentioned P444 had, that the joint just wasn't - didn't have quite enough of an angle on it and that she had ongoing difficulty walking because of that. Subsequently, I similarly also have performed corrective surgery in Maryborough to re-adjust the angle.

And again it was Dr Krishna?-- I believe so. That's what I recorded at the time. I don't have the operation report with me.

It will reveal Dr Krishna. The final patient you discuss is a

P446?-- That's right, yes.

COMMISSIONER: Did you tender that one?

MR ANDREWS: I tender it, Commissioner.

COMMISSIONER: That's 408.

ADMITTED AND MARKED "EXHIBIT 408"

MR ANDREWS: Again, I'll provide a clean copy for the exhibit list.

COMMISSIONER: All right.

MR ANDREWS: The only report that I have to hand of yours relating to a P446 is the one which appears on screen as dictated on the 12th of August. It suggests no symptoms and doesn't advise me what it was about that procedure that concerned you?-- Right. I believe this patient didn't actually come through the patient hotline but was just routinely followed up. It's a patient who had a very nasty fracture and certainly one which would be very difficult to treat for anybody. I'm not involved in that type of trauma surgery anymore being at an elective hospital, but it's one where the - it - it was treated, the break wasn't well reduced, he subsequently had a second operation but, again, the reduction of the break was - I didn't think was adequate. Certainly, these are nasty fractures and of all the ones that are badly managed, it tends to be this type of break. But nonetheless, this one stood out to me as one that a better result would have been hoped for.

So that I can clarify things, I'll put up on the monitor what appears to be an operation note with respect to the first operation?-- Yes, yes.

Would you look at this operation note of the 24th of May 2004. Is that the first procedure, the open reduction and internal fixation of a fractured tibial plateau on the left?-- I suspect it is but I couldn't be certain because they were both a similar procedure. I'd have to see the two operation notes together.

Very well. I have the second which is described as an EUA and screw fixation tibial plateau left?-- Right.

Are you able to say which of the two is the - is the one which causes concern for you?-- Both of them, mmm. The second one was done shortly after the first. I presume because it was seen that the fracture wasn't properly reduced and held but unfortunately the second one didn't actually achieve what it set out to do. And on the second operation - the first operation, everything was opened up to put it back together.

It looks from this as though on the second one, the screws were put in to pull it together but I don't think that could have been achieved without opening everything up.

Right. Well, Doctor, I may have to put these matters to Dr Krishna and Dr Naidoo and so that I can understand them well-----?-- Mmm, yeah.

-----would you tell me with respect to the first operation, that is the one of May 2004?-- Mmm.

What it is that you suspect was done that was done inadequately?-- These are complex fractures and what it involves is the break actually extends into the knee joint. The joint services are split apart and some of the bone are pushed out of the way of the joint. So to give it the best chance of doing well long-term - I mean, a lot of these injuries, no matter how they're managed, will get, subsequently, problems but it will give it the best chance. The bone really needs to be reduced back into the right position and then brought together and held there. It doesn't appear with either operation that with - with the first operation the screws that were put in were too short to get across the two bits of bone and hold them together.

How do you deduce that?-- From the X-rays, mmm, X-rays I have seen subsequently, that were taken between the first and second operation.

And does the fact that there was a need for a second operation give you supporting evidence that the screws were too short?-- Both too short and there was a bit of bone from the joint which hadn't been put back into place.

Where would I find those X-rays?-- I saw them in the outpatients department of the Hervey Bay hospital but I haven't seen them since.

Thank you. And with respect to the first operation, is it only the length of the screws that you regard as the - as a matter of concern?-- No, I think things just hadn't been reduced and put back together well. Having said that, they are very difficult injuries and of all the ones we see that aren't done well, it is this particular type of one - you know, it's not a - it is not an unknown situation to see this type of fracture not well managed. Having said that, I think the management as far as I saw it on the subsequent X-rays, you know, was inadequate.

Thank you. And with respect to the second procedure, which was performed in June 2004, was there something about that which you regard as showing that there wasn't the reasonable care you'd expect from an orthopaedic surgeon?-- I'm not sure what the term wasn't a reasonable care, but certainly the second operation was to put in a second lot of screws to try and pull the bone back together but I suspect it wasn't recognised that the bones were in the wrong place and, you know, couldn't be pulled back together with just the screws. So-----

COMMISSIONER: An experienced orthopaedic surgeon would recognise that?-- Yes.

MR ANDREWS: And is that why you say with the second operation they really ought to have opened up the wound again-----?-- Put the bone back together, yes. Moved bits of bone back into place.

And as a result of the failure to recognise these things, has the patient suffered any unnecessary consequences?-- In the short term it doesn't seem as though he has. In fact, for the sort of injuries he had, he functioned surprisingly well. This injury, even well managed, has a significant chance of developing arthritis later in life, and possibly we are not talking many years down the track, and the better the reduction is performed, the better the chance of avoiding that or prolonging it as far as possible. Certainly he doesn't seem to have suffered short-term problems from it.

Does it seem reasonable to conclude that the prospects of his suffering arthritis later are increased because of the way these procedures were performed?-- Yes.

COMMISSIONER: And it is likely that he will suffer arthritis in the long-term?-- It is, which he may have anyway. But it is possibly likely to be at an earlier stage than he otherwise would have.

Earlier and worse?-- Yes.

MR ANDREWS: I tender your report and the two operation notes extracted from the patient's hospital file.

COMMISSIONER: That will be Exhibit 409.

ADMITTED AND MARKED "EXHIBIT 409"

MR ANDREWS: You have met both Dr Sharma and Dr Krishna?-- I have, yes.

And that was at the Hervey Bay Hospital when you were up there on one of your numerous visits?-- I met them a number of times up there, and we have also discussed patients up there. Part of the time I was there, they were continuing to run fracture clinics and they would sometimes ask for my opinion. On a couple of occasions, they asked for my opinion on people in the Emergency Department.

You visited, in fact, about 13 times?-- Not sure of the exact number. I thought it was probably around nine or 10. I think at the time I gave that report, I think it was about 15 days. I have been up there for two days subsequently.

In those 15 to 17 days you have been up there, have you had an opportunity to form a judgment about Dr Sharma and Dr Krishna and their willingness to seek advice?-- Well, certainly the times I was there they were quite willing to come and ask my opinion on things. Again, I suppose I'd say what I said before about the operative practice - you know, that I see a very selected time frame. I don't see what the normal practice is.

Do you mean you haven't seen them operate?-- I haven't seen them operate, but even sort of giving an opinion on these patients and the ones I've seen in - as a review from the hotline, I mean, I'm not sure what size - whether I'm seeing five problem patients out of 50 or five out of 500, or what type of operations they have done or haven't done and what the outcomes are.

Thank you. I have no further questions, Commissioner.

COMMISSIONER: Thank you. Have counsel agreed upon the order of asking questions?

MR FARR: I can go next, Commissioner. I'm happy to do so.

COMMISSIONER: Have you agreed?

MR ALLEN: The general order is the patients and then the nurses and we don't have any questions.

COMMISSIONER: Okay. You are next, Mr Farr, then?

MR FARR: Happy to oblige.

COMMISSIONER: I would be grateful, in the future, as I have said several times now, if counsel could agree.

MR FARR: Yes.

CROSS-EXAMINATION:

MR FARR: Doctor, I'm Brad Farr. I'm representing Queensland Health in these proceedings. Can I ask you this: I take it you know of Dr Morgan Naidoo?-- I do, yes.

Would you describe him as an experienced orthopaedic surgeon?-- He is, yes.

And I do not understand your evidence to be that experienced orthopaedic surgeons can't make mistakes?-- Mmm.

Everyone can make mistakes, but one would hope that the greater the degree of experience, then the less the number or, perhaps, the magnitude of mistakes; would you agree with that?-- Yes.

And perhaps an example of how everyone can make mistakes might be the patient that you last discussed - that's the boy, P446?-- Sure.

Because we have seen in the operation notes for both of the operations that my learned friend just took you to that the surgeon on each of those occasions was Dr Naidoo?-- It was, yes.

And Dr Krishna was merely the assistant on each of those occasions?-- Yes.

COMMISSIONER: Do we know that, in fact, Mr Farr? We know that was a fact-----

MR FARR: If we are going to assume something, Commissioner, we will have to assume what's in the notes and then find out contrary-----

COMMISSIONER: I suppose so. But in view of the evidence that Dr Naidoo was hardly ever there-----

MR FARR: I can indicate, consistent with my instructions, that Dr Naidoo was the surgeon on both occasions and that's consistent with the notes that are throughout the records for this patient.

COMMISSIONER: All right.

MR FARR: An assistant in such circumstances might play a relatively minor role?-- That's right, yes.

The responsibility for the carrying out of the procedure and the way it is done is with the surgeon - it lies with the surgeon, doesn't it?-- It does, yes.

All right. The point that you make in your evidence in relation to the rate of complications, if you like, of Dr Krishna or Dr Sharma is, as I understand it, the system, as it has been set up, is such that any patient that might have a potential problem or a concern or just a worry and just needs some reassurance was able to come and see yourself, for instance, to receive whatever advice was appropriate in the circumstances and whatever follow-up treatment might have been appropriate in the circumstances?-- That's correct, yes.

And the difficulties that I perceive you have been speaking of is that you don't know, for instance, how many patients haven't come forward because they have got no worries, no problems, no difficulties. You are seeing those that only have a concern of some type?-- That's right, and I haven't seen any sort of figures on how much surgery was done there, what surgery was done there, what their outcomes otherwise are.

It is in that context that you speak of not knowing whether you were dealing with five out of 50 or five out of 500 or

whatever the figures might be?-- That's right.

Thank you. Of the 40 or so people that you did see and review, my understanding is that you have seen evidence of appropriate competent surgery?-- Yes.

And you have seen evidence, as you have discussed in the course of your evidence here today, some areas where there has been inappropriate decisions or inappropriate procedure in one way or another?-- That's correct, yes.

You have seen, I take it, patients - and I'll have to ask if you can test your memory for this - but I take it of the 40 or so people that you did see and review, that some of those people would have been patients of Dr Sharma, some of Dr Krishna and some of another doctor?-- There were, yes.

Okay. In so far as Dr Sharma is concerned - and if you are unable to comment upon this, please say so - but did you find any evidence in the patients or the charts that you have seen to suggest that his clinical and surgical skills were poor?-- Apart from the one case which I've highlighted where he did an operation I think inadequately, I don't believe so, no.

Okay. In relation to Dr Krishna, upon an overall assessment of what's been provided to you and what you have seen, would you form the view that he lacked basic surgical and clinical skills?-- Again, apart from the patients I've highlighted, I haven't seen enough to be able to say that, no.

Even on those that you have highlighted, they don't, as I understand it, necessarily mean that it is suggestive of a lack of basic surgical or clinical skills; for instance, on some of these cases you have spoken of, you were referring to an angle of fixation or reduction not quite right; you were speaking of small margins for error, as I understand it?-- I suppose it is an issue of - you can't describe someone in training as either totally competent or incompetent and I haven't seen enough to assess where the level of competence of either of those doctors sits.

All right. To form an opinion in that regard, I take it that one would need to conduct a very thorough examination of, perhaps, past patients, as well as perhaps look at surgical technique on an ongoing basis for some time?-- Generally, to form the impression that someone was competent, I think you would need to do that. I mean, it is possible if someone - it's not possible that you could form that opinion from the small number of cases.

Certainly. And you have been unable to do that from the small number of cases you have seen here, but you can't take us to the level that the doctor might-----?-- To say what their level of competence is and what they should and shouldn't be doing.

Thank you. Equally, in a couple of the cases that you have referred to - for instance, I think P444 and P445

might be good examples - that's not necessarily the carrying out of procedures in circumstances where Dr Krishna might have thought, "I'm not good enough, but I'll do it anyway." You were asked some questions about that type of thing at the beginning of your evidence this morning?-- Mmm.

My understanding of the nature of the problems that you found were that the fixation had this - had that small degree of error in so far as the angle was concerned?-- Moderate degree of error, yes.

However, we know, I think, in relation to P445, that she had an identical procedure conducted, I think a couple of months previously, on the other foot; that's correct?-- That's correct, yes.

And if, for instance - and I'm not expecting you to know this from memory - but, if, for instance, Dr Krishna had performed that operation, it would seem - sorry, whoever performed that operation has performed it successfully?-- That's correct, yes.

If that was Dr Krishna, it might tend to suggest - at least in his own mind - he is able to perform a subsequent operation of an identical nature on the other foot a couple of months later?-- I think that's reasonable, yes.

And I understand the essence of the point that you have made really - and please tell me if I've misunderstood this - is that had there been supervision in place at the time of that second operation in her case and the operation in P444's case, that that moderate angle difference might have been discerned by the specialist and corrected there and then?-- That's correct, yes.

It is not necessarily the case that it would have been, because these things, as I understand, are sometimes very difficult to achieve-----

COMMISSIONER: He said "likely to".

MR BODDICE: Likely to. Thank you. In relation to P443 -----?-- Yes.

-----and you can check the notes again if you wish - but I think she was 66 years of age, I read?-- She would be 66 now, yes.

All right. And she had some other health problems. I think I read that she had surgery delayed for a period of time because of a heart condition and had a stent inserted some months prior to this surgery that we are discussing here today?-- Mmm.

I assume that an operation on a person - any type of operation - on a person with perhaps other serious health considerations is conducted as inobtrusively as possible?-- Mmm.

And might it be the case that a surgeon conducting the type of operation on her hand that she had would be keen to keep the degree of the wound - the incision as small as possible for the purposes of her subsequent recovery; is that a consideration in these circumstances?-- I don't think it should have been in this case, no.

All right. And the issue here is that a larger incision would have resulted in a better outcome, as I understood it?-- That's right - not necessarily a larger incision, as in just making a longer one, it wasn't so much that the surgery was done through a small hole that didn't give exposure, it is more the lines of where the incision is made. Because of the bends in the finger, it tends to be important.

The healing of the scar, is that, in itself, a consequence of the way the procedure was conducted, or is that something that is inherent in the-----?-- Keloid in itself is usually something that's inherent in a person; however, in this particular situation, doing it through a straight incision down the middle of the finger is known to have a very high level of risk of forming excessive scarring, and I believe this lady had other scars which went keloid.

Keloid, I take it, is excessive scarring?-- It is. It is thick scars that contract.

All right. If a scar heals keloid, for instance, on the palm of one's hands, that contracts the skin to some degree greater than a normal scar?-- It does, and that then affects the movement in the fingers.

All right. Again, I understand your evidence to be, and the essence of what you are saying is had there been adequate supervision at the time, it might have been more likely that the appropriate incision was made?-- I think in this particular case, it is likely, yes.

Once again, this was the type of surgery that I think you said is carried out frequently by generalists. You might not necessarily agree that that should occur?-- By "generalist", I was referring to a general orthopaedic surgeon, rather than someone with purely a hand practice.

Rather than Dr - the fellow from the RBH, someone in general practice, perhaps, out in the country?-----

COMMISSIONER: No, a general orthopaedic surgeon as opposed to-----

MR FARR: One in general orthopaedic practice in the regional areas?-- Yes, in the main, that would be appropriate.

Thank you. Commissioner, those are all the questions I have in relation to these matters. Can I place on the record that whilst I have had the opportunity of conferring with Drs Krishna and Sharma in relation to Dr Crawford's statement, it has been a little difficult until this morning to, in

particular, identify what the areas of concern were in so far as skill levels or competence. So, I've taken it as far as I can, given the instructions I have received. There might be areas that Dr Krishna will need to speak of that I haven't put to this witness, but I'm afraid they are the circumstances of what's occurred.

COMMISSIONER: Thank you.

MR FARR: There is one other area I wanted to ask Dr Crawford about, however: Doctor, have you also had an opportunity of looking at patient charts for some patients that have been referred to in Dr Mullen's evidence?-- I had been asked to look at those patient charts. I have reviewed them. I was asked to give an informal verbal opinion on them but I didn't make any notes at the time-----

Do you feel able to be in a position to give information on the patients if given their names?-- No.

Thank you.

COMMISSIONER: Who's next?

MR DEVLIN: I'll go next, Commissioner.

CROSS-EXAMINATION:

MR DEVLIN: Doctor, I'm Ralph Devlin representing the Medical Board. In the context of P445, did I understand you to say that in relation to the MTP fusions, that even in the best of circumstances, it can end up not quite at the right angle?-- It can.

What is it about that process which leads to that result on some occasions?-- It is really just a matter of making the best judgment you can at the time. Unfortunately it is the angle - how much the toe is cocked up that seems to be significant. With an X-ray in theatre it is often difficult to obtain good films that really show it well, even post-operatively sometimes. It is a matter of making a judgment - putting the foot in the position it will be afterwards and seeing if it looks right.

See if I have got this right then: is it sometimes, even in the best of circumstances, due to the vagaries of the X-ray itself that a not quite right result is arrived at? Is that one factor?-- You would rely more on the appearance of what you were seeing as much as on the X-ray.

Yes. Is it a factor also as to the vagaries of the patient - him or herself - as well that sometimes these things don't end up quite right?-- I'm not quite sure what aspect you are asking me. One point is: is there anything the patient did

afterwards that would affect it, and generally I would say no, because it stays in the position that it was put in at the time of the surgery-----

Going back to the first aspect I asked you about then: is it a judgment call the surgeon makes?-- It is, yes.

What has been P442 outcome after you operated on him on 14 July in year?-- The outcome now should be the same as if he had the originally planned surgery, and in the short-term-----

In the short-term, yes, but it hasn't been evaluated in the medium term yet?-- No, I think I last saw him just at the stage where he was coming out of plaster and starting to walk on it.

The prognosis is reasonable?-- Hopefully it should be good.

Thank you.

MR McDOUGALL: Subject to Mr Farr having questions about Dr Mullen's evidence at a later date, I have no questions.

MS GALLAGHER: No re-examination, thank you, Commissioner.

COMMISSIONER: All right. Do you have any further questions?

MR ANDREWS: No, thank you, Commissioner.

COMMISSIONER: Doctor, thank you for coming. You are excused from further attendance.

WITNESS EXCUSED

COMMISSIONER: We will now adjourn.

THE COMMISSION ADJOURNED AT 11.23 A.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2.30 P.M.

MR ANDREWS: Good afternoon, Commissioner. I call Dr Martin Nothling.

MARTIN NOTHLING, SWORN AND EXAMINED:

MR ANDREWS: Doctor, have you prepared a report of the 22nd of September 2005 of 18 pages relating to Mr Peter Leck?-- Yes, I have.

Perhaps before I go into that, you are a psychiatrist?-- That is correct.

Can you tell the inquiry your qualifications?-- All right. I am MBBS, FRANZCP.

You have been a psychiatrist for your entire career?-- Yes, I have been.

Doctor, your practice includes the assessment of numerous persons for the purpose of providing medico-legal reports?-- Yes, I have a practice where I have been doing that for quite a number of years as well as a clinical practice.

And your report of 18 pages contains opinions. They're honestly held by you?-- Yes, they are.

And the facts as you recite them, to the best of your knowledge they are true and correct?-- As far as I am aware they are true and correct.

I tender a copy of Dr - oh, Dr Nothling's report in an amended version is already before the inquiry.

COMMISSIONER: It is.

MR ANDREWS: Doctor, you were given the advantage of some reports of Dr Jeremy Butler to review in forming an opinion with respect to Mr Leck, is that correct?-- Yes, that is correct.

It seems from the report of Dr Butler of the 8th of June, 2005 - do you have copies of those reports with you?-- Yes, I do. Yes, I have that one open in front of me.

So that the Commissioner can follow this, I will put a copy of its first and second pages on the monitor. You will see a monitor before you and the image will appear. At the bottom of the first page, it seems that at least by the date of that report Mr Leck wished to present his evidence to the inquiry and then as expeditiously as possible?-- Yes. Well, that's what I would read into it, yes.

It is possible, is it not, that a person with anxiety can, nevertheless, see the advantages of expressing his own story in evidence and getting that unpleasantness out of his prospect?-- Oh, certainly giving evidence to a Commission such as this would be an anxiety provoking experience for most people, so I would anticipate that the average person would have some anxiety and would probably want to get it over and dealt with.

May I see the second page, please? Dr Butler had expressed the view that for Mr Leck there was some advantage in selecting Brisbane as a place to give evidence as opposed to Bundaberg. Was that a reasonable view to hold at that time?-- Well, I didn't see Mr Leck at that particular time but I would have to be guided by, you know, what he told me, but particularly by the reports of Dr Butler. And, I mean, all I can say is in view of the emotional factors associated with Bundaberg, I would have thought that's probably a reasonable conclusion at that point in time.

And at that point in time it seems that Dr Butler was urging that Mr Leck be able - or be allowed to give evidence and in Brisbane?-- Well, that's what he appears to be saying in the report, yes. I think he is raising at the bottom there - you have highlighted it there - about the risks for saying they would be substantially less in Brisbane as opposed to Bundaberg.

Thank you. And is it the case that for a person such as Mr Leck, the circumstances in which he gives evidence can affect the degree of anxiety, and, indeed, the degree of any adverse consequences that might flow to him?-- Yes, the conditions that Mr Leck, or anyone who gives evidence, would certainly have an impact on - if they were suffering from a psychiatric disorder, would have an impact on that.

Even when Mr Leck saw you, I see from paragraph 8 of your report, on about the third line, "he expressed the view that he wanted to get the whole matter over and done with".

COMMISSIONER: Sorry, where is paragraph 8?

MR ANDREWS: Page 8.

COMMISSIONER: Oh, page 8.

MR ANDREWS: Commissioner, do you have a copy of that?

COMMISSIONER: I don't have a page 8. The amended report.

MR ANDREWS: The parties have been given the full copies, Commissioner, but for the confidential - because of the disclosure of material-----

COMMISSIONER: Oh, yes, I understand all that, but, as it turns out, I don't have it, I only have the report which is in evidence, which is - it goes from page 2 to page 15.

MR ANDREWS: I will hand up a copy, Commissioner, so that you can follow this particular line of questioning.

COMMISSIONER: Page 8.

MR ANDREWS: Page 8 on the third line, it seems that Mr Leck, at the time that you interviewed him, had a desire to get the whole matter over and done with, is that correct?-- Well, I think he just wanted to see this whole matter away and removed.

Well, at the time, was that consistent with his own wish that if he was to give evidence it was to give evidence as soon as possible?-- That wasn't the - my understanding. It was more that he just wanted the whole matter over and done with, rather than he giving evidence.

COMMISSIONER: Do you think he would feel some better sense of closure if in fact he did give evidence?-- Well, he may feel a sense of closure, but, yeah, I have been asked to address a slightly different question-----

I understand that?-- -----about him, but certainly I think he would feel a sense of closure if he were able to give evidence and give it reliably.

Yes. I wasn't so much concerned with the reliability but he might feel some satisfaction that he had got through the evidence process, whereas if in fact he never gave evidence he might feel a little the worse for that. Is that a possibility, or likely?-- Well, it is a possibility. I wouldn't say it is likely, yeah.

All right.

MR ANDREWS: It is the case that after seeing Dr Butler - I beg your pardon, his first appearance in the inquiry was on about the 25th of May 2005, as I recall, and it seems, from Dr Butler's report of the 20th of June 2005, that Mr Leck had seen counsel assisting the inquiry shortly before being reviewed on the 17th of June by Dr Butler. Do you have Dr Butler's report of the 20th of June with you?-- Yes, I do.

I deduce this from the first paragraph. It is the case, isn't it, that when Mr Leck saw counsel assisting the inquiry, even after having been cross-examined by Commissioner Morris, he felt that he coped relatively well, that he was able to respond appropriately and he did not suffer significant sequelae, is that the case?-- Well, that's my understanding of what Dr Butler is conveying there.

Does that suggest that the manner of the questioning of Mr Leck and the circumstances - the physical surroundings, perhaps - can have a bearing upon whether he suffers any significant sequelae, and whether he is able to respond appropriately?-- Yeah. I believe that the manner of the questions and the situation that he is in, yes, would make - would make a difference in terms of sequelae. In other words,

if he were placed in a very adversarial Commission situation, that would be different to providing information in a more, should I say, sheltered environment.

COMMISSIONER: Also the formality of something like this, where - no doubt you were confronted with cameras outside when you came in. He would be certainly. He is confronted by cameras in the courtroom, which you can see. There don't seem to be so many of them here at the moment but there would be if he gave evidence in this situation. If that didn't occur and if, for example, he were asked questions by a counsel in, say, a smaller room, not something confronting like a courtroom, where everyone sat around a table and asked him the questions, would that be less harmful to him?-- Well, it would be less harmful to him but I think, Commissioner, that his condition has deteriorated from this particular time. That's from the history I have taken and my understanding of his treating psychiatrist's reports.

Yes?-- So the situation is a little different now to what it was then. I think one needs to understand depression and anxiety to understand sort of why that would be, but essentially there is a change, I believe.

Right.

MR ANDREWS: Your diagnosis is that he suffers symptoms of a major depressive episode and general anxiety disorder, is that right?-- That is correct.

In your experience, have persons who continue to suffer symptoms of those matters you have diagnosed - do such persons ever, while suffering those symptoms, give evidence in Courts-----?-- Oh-----

-----in your own experience?-- Right. Yes, in my experience some people would have given evidence in Court cases, probably a fairly simple fact evidence rather than becoming involved in fairly difficult cross-examinations. But, by and large, most people with this degree - most individuals who have this degree of symptomatology would find it very hard to concentrate and would have memory problems, and would become rattled or confused quite easily if they were confronted with the situation of having to provide accurate evidence.

There would be a difference - when you are considering accuracy and reliability, a difference between evidence that is concerned with details such as dates and sequences, a difference between such evidence and evidence of a more general kind, such as - I have extracted something from page 5, which I can put on the monitor, but it is evidence of a kind that touches upon topics of general interest to this inquiry. Do you see the topics raised in both those paragraphs?-- Yes, I do.

There would be no concerns - well, fewer concerns about his ability to reliably give evidence with respect to those topics?-- Well, yeah, I would say that they are very general

topics and - I mean, generally, reliability on something as general as that probably wouldn't be a great difficulty.

Indeed?-- If it was very general.

He would be rather an expert on such matters, wouldn't he, and matters within his expertise shouldn't be of much trouble to him to recall?-- Well, I think if you got into more detail rather than that general information he has given me there, I would anticipate that he would start to find it fairly difficult.

And his views about wanting to credential Dr Patel and saying that there had been difficulties with respect to it, they would be matters that he would be likely to be reliable about?-- Well, I think he could certainly describe to me generally that he had concerns about that, and I think I have detailed that in my report. But, once again, I think if he got into more detail and was examined at further length about that, there would be reliability problems as well as - he would find that fairly stressful, given his psychiatric status.

COMMISSIONER: But that would be something to his credit rather than to his detriment, wouldn't it, that he really was concerned that Patel had not been credentialed and privileged. I just wonder whether he would have greater difficulty in answering questions which are likely to be to his own detriment, in other words critical of him, than in answering questions, either by a general nature of the service provided there or specifically, which might go to his credit in some way?-- Commissioner, I believe that if he was subjected to questions which really were testing out his credibility or whether he had done the right thing or not, I think that he would find that more difficult. I would expect that someone with anxiety and depression such as he has would certainly find it more difficult than just the general type of information that he has provided here.

Yes. Could I just ask you something more general about his condition? I imagine almost anyone who is likely to have the criticisms made of him that Mr Leck has already had made of him, and is likely to be made of him during the course of questioning, would have a substantial degree of anxiety about coming and giving evidence to a Commission like this, and that anxiety would have been increased by the form of questioning by the previous Commissioner. You have said that. You said that certainly is the case. How much does his condition really accede that? We would all be anxious in that situation. How far is he beyond that, in terms of seriousness of his condition?-- Well, I believe that, yes, he is a fair way beyond that because he really has all the symptoms, not just of an adjustment disorder with anxiety or a short term anxiety. I mean, he really does have much more significant symptoms than that, and, as a psychiatrist, I would say that, you know, he is much further down the track in terms of a decompensation than that, and if he were - I mean, for instance, trying to work, you would be advising him, "Look,

you have got to take a break. You are not going to be able to concentrate on your business the way you are." The way he is at the moment, that's the sort of analogy I would use to explain that.

MR ANDREWS: Doctor, the responses that you elicited from him, you would expect them generally to be reliable?-- The responses that he has given me? Well, I mean, he has just answered my questions, which are fairly simple questions about how he is feeling and how he is sleeping and what he is doing. That's all I can say. I don't have any other information outside to-----

Well, I am thinking now in terms of three topics raised on page 11 of your report, which I will put up on the monitor. I think they are from about the second paragraph. I folded it so that it conceals-----

COMMISSIONER: You have not completely concealed it.

MR ANDREWS: I have attempted to conceal the personal history. There are three sentences there with three topics. I gather that they are each matters that Mr Leck volunteered to you?-- Yes, that is correct.

Does that suggest that - doesn't that suggest that he at least has some desire to volunteer this information?-- Well, he certainly volunteered that information to me, so I would anticipate that he - I would say that, yes, it is something he wanted to say.

What I am trying to explore is whether, in a benign Commission environment, whether there would be some advantage for Mr Leck, if he were given an opportunity to expand upon those - for instance, those three topics that he volunteered to you?-- Well, all I could say is that it may or may not be helpful to him, but I would - at one level but I would anticipate that once questions got deeper, I think he would then suffer more anxiety and probably his overall psychiatric state would tend to deteriorate if he were pushed. That's what I would say. In other words, if he were pushed to provide further information. I mean, I think what he told me there was fairly simple, straightforward recollections of what happened.

If Mr Leck, for instance - I am trying to go - look for an extreme - if he were asked to provide a statement that he could provide simply to his own lawyers that ultimately was to be passed on to the Commission of Inquiry, you wouldn't expect that to cause any dangerous situation for Mr Leck, would you?-- I think that would be the least threatening situation for him, and if he were able to just go through the points with his lawyers and have records there, well, I don't believe that that would be a major threat for him. But, I mean, I would have to say it certainly would be another stressor, but it wouldn't be anything like appearing in a Commission or appearing in another room where it was a less threatening environment.

And let me take - well-----

COMMISSIONER: So that's not a significant factor in his condition? That would not make a significant difference to his condition, providing a statement of that kind?-- No, but I would still be concerned about reliability. But-----

Yes, that's a different matter?-- -----obviously if he had time to go through all the documents and it wasn't a pressured situation-----

Yes?-- -----I think that would be a preferable way, if there had to be one way or the other.

MR ANDREWS: Now, if, for instance, Mr Leck were required to give evidence before this Commission of Inquiry, on the assumption that all persons questioning him tried to be as sympathetic to his condition as possible, but assuming that, notwithstanding their best efforts, lawyers questioned him in a way that increased his anxiety, am I right in assuming from page 17 that such a process would adversely affect his psychiatric disorders, but only temporarily?-- Yes - well, I have stated that very clearly there. Yes, I would say appearing before a Commission and being examined by lawyers would lead to certainly an adverse change in his psychiatric disorder, but it would be on a temporary basis. But if you asked me how long would that be, I couldn't answer that. I don't know. I could only, as a doctor, say that certainly I wouldn't expect that it would last forever if it was done in an understanding way, the questioning.

If, for instance, it is ordered that Mr Leck appear before the inquiry to give evidence and to be cross-examined by several parties, would any danger to him be diminished if he were, for instance, given - or his medications were considered by his treating psychiatrist and if he had, for instance, the company of his treating psychiatrist?-- Well, I am not sure that he would need - I mean, you are asking me-----

Whether you want to come too?-- If he were to be in that situation - well, I am not sure you would need a psychiatrist sitting beside you, but, I mean, you would certainly need access, if there were breaks or if one felt unwell. I am not advocating that that be DONE but I am just saying if that were to be done, it certainly, I think, would be reliant on advice from his psychiatrist.

Well, it would be sensible, wouldn't it, for him to have an appointment to see his treating psychiatrist for a time as soon after the inquiry as possible and for the - indeed, for him to have seen his treating psychiatrist before giving evidence so that any change to his medication could be considered?-- Mmm-----

Would that be sensible?-- You would have to be very careful, though, as a treating psychiatrist. If someone is ordered to give evidence in his psychiatric state, you would have to be very careful adjusting medication, because a downward

adjustment can often lead to the person concerned feeling much more anxious or more depressed, which could be quite a quick reaction. Any increase in these medications - and they are fairly powerful medications - could lead to more difficulties with concentration and memory, because he is on a benzodiazapine, and that clearly is a class of drugs that can cause memory impairment. So, I mean, you can see the problem to treat him when there is the pressure of a Court case is that the treatment you are using may, over this period of time, be causing even more difficulties for him. But there is no other option. It is a bit like treating someone with a bad back. I mean, sometimes you have to use a treatment which may mean that he is not going to be so good going out and working for a while but ultimately the person with the bad back will come good. It is a little bit like that situation.

Doctor, would it alleviate the dangers if he were to be examined in a smaller room by a smaller number of persons, perhaps with the public excluded from the room. You are nodding; I'm assuming that means you're agreeing with the general concept?-- Well, I'm not recommending it but I'm saying if that was the choice as opposed to being in an open Commission, yes, that would be a less stressful situation.

COMMISSIONER: So is that less likely to cause him harm or likely to cause him less harm?-- It will be likely to cause less harm.

MR ANDREWS: Well, if you were - I'm asking you to consider probabilities. Is it your opinion that if he is examined in a room, for instance in a round table atmosphere, by lawyers who are subject to the discipline of the Commissioner if they overstep the bounds, in circumstances where questions are phrased with a view to minimising any anxiety to Mr Leck-----?-- Mmm.

-----with his ability to seek an adjournment or have his lawyers seek an adjournment on reasonable occasions where they apprehend that he might be becoming over anxious, in circumstances where he will have an appointment shortly thereafter to see his treating psychiatrist, where for instance the press is excluded but there is an audio - I beg your pardon, the answers are transmitted to another room where they can be picked up by any members of the public who wish to listen, or members of the press, the probabilities are that that won't cause him any significant damage, aren't they?-- Well - well, I would say that it would - that it would certainly exacerbate his condition. I mean, he - he is really having to recall information and that certainly would - would do that and, I mean, his reliability would still be a difficulty I would say in terms of giving evidence.

If you can put reliability to one side?-- All right.

It is his condition?-- Mmm.

You say it would exacerbate it but then any witness giving evidence tends to have an exacerbation of their condition, no matter what it is. They're all going to be anxious, aren't they?-- Well, even if you're not anxious to start, you probably - it would be part of human nature to be anxious in the middle of it but the problem is with Mr Leck, he's starting from a base of having anxiety and depression so-----

But I was asking you for your opinion about whether with that scenario I described, whether you'd agree that he probably would not suffer any significant aggravation of his condition and you said he-----?-- Oh, just his condition. Well, I would say that there would be a temporary exacerbation but probably in the longer term I wouldn't expect that that situation would cause an exacerbation but I don't know for how long. If you ask me how long that's going to cause an exacerbation, I couldn't say. I don't think anyone could say that but I could say it would make him feel worse but I don't anticipate that

he would feel as - he wouldn't be exacerbated to the extent that he would be in an open Court.

COMMISSIONER: Well, could I just, just to get some idea for me, if I used the terms "mild", "moderate" and "severe", if he were to give this evidence in an open Court, this room here, in the circumstances of this, with television cameras and so on, would describe the exacerbation, the temporary exacerbation of his condition in that situation to be mild, moderate or severe?-- Oh, well, I would say in his condition, yeah, he probably - that would to him be a fairly severe or moderate to severe exacerbation of what he's got I would say.

All right?-- But I would say then if he were in a quieter room with a smaller number and it wasn't a big courtroom, well, I'd see it more as, you know, moderate to mild, more in that area there.

Thank you.

MR ANDREWS: I have nothing further, Commissioner.

COMMISSIONER: Okay. You have questions, Mr Mullins?

MR MULLINS: Thank you.

CROSS-EXAMINATION:

MR MULLINS: Doctor, at page 16 of your report, I don't have the exhibit report, simply the-----

COMMISSIONER: Sorry?

MR MULLINS: I don't have the exhibit report.

COMMISSIONER: Don't worry about that. We know what you're talking about. I don't either.

MR MULLINS: Page 16 in the middle paragraph, do you have the full report, Doctor?-- Yes, I do. Yes.

You make it clear that from your perspective the major factor contributing to the decompensation of Mr Leck's decompensation into the major depressive episode was the appearance before the Commission on you say 26 May but it is 25 May 2005?-- Mmm.

That was the major factor; that's correct?-- Yeah, of the further decompensation, yes.

Did you identify any other factor?-- Well, you know, after - after that, there was the anticipatory anxiety, "This is going to be more of this and this is what's ahead of me", and that was an ongoing stressor for him and I - I believe it - I mean, those sort of decompensations come on often

gradually and then you just see the effect of that coming through over the next month or so, or few months as I believe has happened in his case.

The critical factors in the original decompensation were firstly what you described as the anticipatory anxiety?-- Mmm.

That's correct. And the anticipatory anxiety is a term of science, isn't it?-- Well, it's a term used by psychiatrists to describe the anxiety that individuals would experience when they're thinking about something that's going to happen and they have some bad associations with that particular event or they - they believe something difficult is going to happen and that's anticipatory anxiety.

That's right. The anticipatory anxiety is generally something that someone would experience when confronted with a challenging event, what they perceive to be a challenging event; that's correct?-- Oh, okay. Well, yes, it's all a matter of degree of how much anxiety the person is experiencing to start with and then if you add on anticipatory anxiety, you're compounding the problem. I mean, for someone who doesn't have anxiety and then you anticipate something difficult is going to happen, you're going to reach a certain level of anxiety but it may be nothing like what a patient suffering from a psychiatric disorder may then - the level they may reach with anticipatory anxiety could be much higher because we all know and as doctors we know when people have a psychiatric disorder, they often seem to overreact to all sorts of things that are going to happen but that's the natural history of these disorders.

Can I distinguish between the anticipatory anxiety of which you speak from which we see in the generalised anxiety disorder as being the apprehensive expectation, which is quite a different phenomena, isn't it?-- Well, it all merges into one, really, in the end because if you have a generalised anxiety disorder, you are going to be generally anxious most of the time. If you're anticipating something you perceive is going to be difficult, there is going to be a - certainly a further step up in terms of the level of anxiety, and we call that anticipatory anxieties exacerbating the underlying anxiety.

Coming back to the problem that arose at the earlier Commission of Inquiry?-- Mmm-hmm.

Mr Leck had in the first instance the anticipatory anxiety?-- Mmm.

And in the second paragraph at page 16 you note that that anticipatory anxiety in fact came true and his worst fears were realised when he perceived a certain experience during the course of that evidence?-- Mmm.

That's correct?-- Yes, his anticipatory anxiety and his fears seemed to come to fruition when - when he actually ended up in

the Commission. I mean, he realised, "This is what's happening."

Yes. You say in your report, "The manner, tone and content of the Commissioner's question confirmed his worst fears"?-- Yes, that's as he explained it to me.

Now, you point out at page 7 of your report that since the time of the appearance before the Commission on 25 May 2005 his condition has been up and down a bit since that time?-- Yes, could you just repeat that, I'm sorry, I didn't quite hear.

Page 7, the second paragraph?-- Yes.

His condition goes up and down?-- Mmm.

That's correct. Well, that's what he described to you?-- Yes.

Now-----?-- Oh, sorry, yes, second paragraph. I'm sorry, yep. Yes, that is correct. That is part of the natural history of these types of disorders though. There will always be some fluctuation.

Yes. So there will be some exacerbation of symptoms from time to time by reason of certain events; that's correct?-- Yes, yes, there will be due to events, and sometimes people with these disorders just seem to have exacerbations and then slight remissions when we can't really pick up any external event, but usually they have an exacerbation when there is some external stressor.

You mentioned then, back to page 16, in the third paragraph, "In my opinion any further appearance before the Commission will now lead to, firstly, significant increase in anticipatory anxiety and, secondly, the severity of the symptoms of the major depressive episode and generalised anxiety disorder"?-- Yes, that is correct.

Now, the symptoms that you describe, can I just show you a copy of an extract from DSMIV. We can see there on the overhead - you're obviously very familiar with this, Doctor - the criteria for major depressive episode?-- Yes.

If we turn to page 7, the symptoms that you describe are at pages 7, 8 and 9. Page 7 you describe poor concentration and you discuss that at both pages 7 and 8. Can you see that?-- Yes, you said poor concentration, yes, that's correct.

Yes. Well, you refer to it at page 7 and then you continue on to some extent at page 8?-- Mmm.

And you're referring there to the - at number 8 in the diagnostic criteria?-- Yeah, I'm referring to the - number 8 is diminished ability to think or concentrate. Yes, that is correct.

The next paragraph you say, "He described that suicidal

thoughts had started to enter his thinking before he left Bundaberg", and you then discuss some suicidal ideation that he had which is referred to in the criteria at number 9?-- That is correct.

The prospect of suicide is a very serious issue for a psychiatrist and a patient?-- Yes, the prospect of - well, suicide is something that psychiatrists have to weigh up all the time with every patient they see, really, as part of the assessment and the ongoing assessment to see how they're responding to treatment.

It's a very significant symptom?-- Suicidal ideation.

Yes?-- Well, it is one of the significant symptoms. Suicidal intent, in other words if someone has an absolutely definite plan, then that of course is taken even more seriously than having suicidal thoughts. And if one has attempted suicide previously and has a definite plan this time, that's taken very seriously and could lead to a hospitalisation of course for a patient.

On reading-----?-- He didn't have suicidal intent. He-----

No. On reading Dr Butler's reports, there is no reference, certainly that I can see, to any suicidal ideation. Is that surprising to you, that the treating psychiatrist has not-----?-- Yes, well, you will have to ask Dr Butler. I really don't know. The history I got was that's how he's been through this period and I'm sure that Dr Butler would have been assessing that during the treatment time.

Dr Butler almost certainly would have known about it?-- Well, I would suspect that he would have inquired about it, yes.

All right?-- I mean, sometimes psychiatrists don't put everything in a report. It just depends. When we're in a treating situation we may not, you know, go through it in the same sort of detail that we do when we write an independent evaluation for a situation like this.

As an aside, for the Commissioner's benefit, of course the college has specific rules about the circumstances in which a treating psychiatrist should give evidence in a medico-legal scenario; that's correct?-- Well, yes, we do - we do have criteria - we certainly have guidelines to guide psychiatrists in that area.

Well, the college generally - the guidelines generally state that it's inappropriate for a treating psychiatrist to be providing medico-legal evidence other than historical evidence?-- Yes, it's - well, yes, I was involved in all of that so I know the process. Yeah, we generally have looked at that internationally and the accepted principle is that as a treating psychiatrist, it is very difficult to get involved in other than providing just factual evidence of, "I've treated Mr Jones. He had", whatever it might be and, "The treatment has been such and such", rather than getting into too much

detail because it does affect the treating doctor/patient relationship and it's - it's seen as too big a risk to get involved in in that area. That's why we advocate independent evaluations in this sort of situation.

On page 8 you identify appetite as being a problem, which I think is diagnostic criteria number 3?-- Well, that's correct, but that was initially. He stated to me that it was less of a problem than it used to be and I noted that his weight, whilst it had dropped initially, seemed to have come back to pretty close to what it was prior to the decompensation. So I wouldn't put a great weighting on the appetite and weight, which is - that's point - or criteria number 3 that you're referring to there.

The next paragraph on page 8 sleeping pattern, number 4?-- That's correct. I would certainly put a weighting on - on the sleeping pattern. I believe that he has had quite a disturbed sleep pattern when you take a detailed history and when he tried to come off even the - I think it was the Stilnox, the sleeping medication he's been on, he needed to - returned to have sleeping problems even though he was on a therapeutic dosage of an antidepressant.

Page 9 you identify two further factors; one is the energy levels?-- Yes, that's correct. That's picked up under point number 6.

Right?-- Which is fatigue or loss of energy nearly every day. I believe that he qualifies for that.

And then the last one that I can identify in that group is interests and activities,which is point number 2 in the diagnostic criteria?-- Well, yes, I - I would say that he - he qualifies for - for that particular point number 2 in the criteria. Certainly lost a lot of interest in things that gave him pleasure before and that is part of depression.

Now, on the next page, page 10, you do refer to suicidal traits again?-- Mmm.

Now, it's the case, isn't it, that when you say then on page 16 that the exacerbation in the severity of the symptoms - sorry, the increase in the severity of the symptoms of the major depressive episode and generalised anxiety disorder are those that you have identified on pages 7 through 10?-- Oh, yes, yes, well, I'm - that's what I'm outlining here.

So he'll have-----?-- You haven't gone through the ones for generalised anxiety disorder but I can assure you he does meet the criteria there; I'm very happy to explain those.

All right. We will go through those.

COMMISSIONER: What's the point of going through these, Mr Mullins?

MR MULLINS: Your Honour, I'm trying to identify the symptoms that are going to be exacerbated specifically by the evidence that's going to be given. If the doctor is going to identify different symptoms from those that have already been identified, I would like him to identify them. I can probably ask him that question without going through the criteria.

COMMISSIONER: That would cut things short.

MR MULLINS: It would. Any further symptoms over and above what you've already described?-- Well, with generalised anxiety disorder you will see there that there are a number of criteria A, B, C, I think it goes right down to F. Criteria A is the excessive anxiety and worry that becomes the predominant feature of the person's life and I think he certainly qualifies there from his description to me. He finds it difficult to control the worry. I mean, I think he seems to be worrying all the time and that was the history he provided to me. Number C was the anxiety and worry are associated with three or more of the following six symptoms, and you will see there that the ones that I have highlighted are being easily fatigued, and you will see "yes", but that's a symptom of depression. There is an overlap because most patients who are depressed also suffer some degree of anxiety. If the anxiety is enough, it may well qualify for the comorbid diagnosis of a generalised anxiety disorder. So he qualifies for that number, that's number C2. Number C3 is difficulty concentrating, which is mind going blank, which is characteristic of people becoming anxious or depressed. And number 6 is sleep disturbance, which is - as I have said, he clearly has. So he qualifies there. And he qualifies for D, E and F, which are more technical points but I can go through if you wish to but he does qualify for those.

All right. At page 16 of your report you identify some of the aspects of his anticipatory anxiety which you consider a little earlier in your report which included some concerns about the fact that he was advised before the previous Commission that he can't use notes, couldn't use notes; that's correct?-- Yeah, that - that would seem to be his recollection of it.

So the provision of some notes would be of assistance?-- Oh, clearly, if he were being examined, yes, I think - absolutely, provision of notes would make it a less stressful situation.

The provision of a detailed chronology so he could get all of the dates into his mind before he hopped into the witness box would be an important aspect in relieving his anxiety?-- Well, it would certainly reduce - certainly reduce the stress of the situation to a degree.

One of the factors previously was his perception - that concerned him previously was his perception that the Commission or that some people were out to get him?-- Mmm.

That's correct?-- Well, that's - that's the feeling he had as I've outlined in the report.

And if his lawyers now explain to him that the Commission will give him a fair go-----

COMMISSIONER: Was that before - he had that feeling before or after he was cross-examined by Mr Morris, that people were out to get him?-- Yes, it was my impression that he generally had that feeling and then he went before it and that seemed to reinforce his feeling.

Yes, all right. Thank you.

MR MULLINS: So if that feeling was removed, that would reduce the anticipatory anxiety?-- Oh, well, certainly it would be some reduction in it, yes, but it's a - it is a - it is a difficult thing for patients to cope with because they - individuals who have these problems, even though it is not logical, sometimes it's - it's a learned response. You get into that situation and the anxiety can come back again even though you know at a cognitive level that this is a different Commission, the approach is totally different, you still may start to develop the symptoms of anxiety and confusion and shakes and start to feel very uncomfortable. So that could well occur but it is - certainly, it would be a less stressful situation.

If this Commission or if his own lawyers with the assistance of the Commission were able to remove many of these matters that give rise to the anticipatory anxiety, his prospects of giving evidence without a significant exacerbation of his symptoms is significantly improved, isn't it?-- Well, I'd say there would be an improvement. I still think there is a significant element of exacerbation of symptoms that would be present.

Now, Doctor, have you seen the interview that Mr Leck gave on 15 June 2005? Have you seen a copy of the transcript of evidence?-- These are the ones that arrived today.

Yes.

COMMISSIONER: Yes.

MR MULLINS: Yes?-- Yes. I'm afraid they arrived too late for me to go right through in entirety but I - I think I looked at the first 27 pages.

In the first 27 pages you can see that Mr Leck does give, at least as transcribed, some coherent answers to the questions that are posed to him?-- Well, I don't think anyone would say that he wouldn't give a coherent answer but it would be the reliability of the answer that he would give that I would be concerned about. There are some - just in the first 27 pages, a number of situations there where he seemed to become a bit confused by it and things had to be clarified but unless you're well aware as a doctor of - of the actual facts, it's a bit hard for me to read through this and say, "Well, you know, they were coherent answers given the facts", because, I mean,

I'm not aware of those.

Thank you, your Honour. Nothing further.

COMMISSIONER: Thank you. Who is next?

MR ALLEN: I don't have any questions, thank you, Commissioner.

MR DIEHM: Nor I, Commissioner.

COMMISSIONER: Thank you. Mr Freeburn.

MR FREEBURN: I would like to ask a few questions if I could, Commissioner.

COMMISSIONER: Yes, certainly. You're not going to ask any questions?

MR BODDICE: I'm not going to ask any questions, thank you, Commissioner.

COMMISSIONER: No, all right. It is you. Sorry, is Mr Ashton going to ask any questions?

MR ASHTON: I am being led today, Commissioner.

COMMISSIONER: Oh, sorry, of course.

CROSS-EXAMINATION:

MR FREEBURN: Doctor, I gather there are - we all will have experienced - there's three categories. First of all, you yourself before coming here today would have experienced today some nervousness about giving evidence even though you have given evidence a number of times, so the ordinary person would experience some anxiety, that's category 1, you agree?-- You're talking about my level-----

COMMISSIONER: No, no, not yours?-- Sorry, I couldn't quite hear you.

MR FREEBURN: Talking about the ordinary person. The ordinary person who comes to Court experiences some anxiety, that's right?-- Right.

And then the medical reports speak about Mr Leck suffering from an adjustment disorder, which I gather is something more extreme and a recognisable psychiatric problem?-- Mmm.

And that's category 2. And then the present illness he suffers from is a major depressive episode and a generalised anxiety disorder and that would be even more extreme, it's the third category; is that right?-- Well, yeah, that is a

simplified way of putting it but I think probably sums it up very well. It is just a matter of realising that an adjustment disorder is more than an expected reaction to a stressor.

Yes?-- In other words, I think you have summed it up well there. Anyone in the situation of having to give evidence in a Court case is going to experience some anxiety and I say that would be normal if they were a person of normal constitution and, secondly, if you had an adjustment disorder, that goes past that.

And you have told this Commission that there are basically two broad problems with him giving evidence: one is the risk to his health?-- Yes.

And the other is the question of the reliability of any evidence he might give?-- Yes.

COMMISSIONER: Are you going to submit that the second is relevant?

MR FREEBURN: It is certainly relevant - we submit it is relevant to the discretion about whether he should give evidence.

COMMISSIONER: Why aren't I, with the assistance of counsel, perfectly capable of determining the reliability this man's evidence in the same way as a jury has to determine the reliability of other people's evidence?

MR FREEBURN: We don't quarrel with that proposition either.

COMMISSIONER: Why is reliability relevant to whether he should give evidence at all?

MR FREEBURN: This Commission would be concerned about whether he is properly defending himself and providing proper answers. If you, as the Commissioner, are going to assess the reliability of his evidence, that's a matter that ought to be investigated.

COMMISSIONER: All right. I won't say any more, but at the moment I can't see it has any relevance as to whether he should give evidence. I see it has relevance to the way in which his evidence would be viewed and assessed, but I can't see how it determines whether he should be called or not, but you can make submissions about that, if you like.

MR FREEBURN: Thank you. So, doctor, let's deal with the first problem. There's the risk to his health. I gather you describe the risk of giving evidence in a hearing like this as being significant?-----

COMMISSIONER: He described it as moderate to severe, but temporary.

WITNESS: I put that in the moderate to severe category.

COMMISSIONER: But temporary. But in another environment, mild to moderate, but also temporary.

MR FREEBURN: Can I deal now with the reliability of evidence he might give, the second category? Your report talks about three difficulties: difficulties with concentration and memory, cognitive process is slow, and organisation of thought is impaired. Those are three problems which affect - would affect him in giving evidence?-- Yes, they are three problem areas that he would have, and that would be part of

depression, you would expect, that would have those sort of difficulties.

And if the Commission is - or somebody from the Commission is to put a letter in front of him and ask him about what happened on those occasions, what do you say about the reliability of his answers?-- Well, I still believe there will be problems with reliability. I think there would be less problems with reliability in that situation than there would be in a Court or hearing - public hearing or Commission setting such as this, but he still does - even if questions are put to him, he does have to concentrate and think through what actually happened, and there still would be a reliability factor that one would have to consider there.

Okay. So, it is still there in a less threatening environment, but perhaps to a lesser degree?-- Yes, it would be a less threatening environment to be in a situation where he was answering questions in written form.

And you were asked about the criteria for major depressive disorder and generalised anxiety disorder. Is it a fair summary of that to say that he had all of those criteria or at least most of them?-- Well, he had sufficient ones to qualify. I mean, he clearly was over the line, if you want to put it that way, in terms of what we look for. I did say - or if I could just deal with major depression first, I wouldn't put any weight on the weight loss or the appetite disturbance that he had initially, because I think that that seemed to rectify. I think it is probably questionable about the psychomotor agitation once I've left - I wouldn't put a big weighting on that, but I think he had enough of the others to be well over the number that one requires. You would very rarely get a patient who would have every one of the criteria. That would be a rare thing. That's why there is a range given, and in the generalised anxiety disorder, he certainly met all of the criteria. Under point (C), he satisfied three of the ones that he had to satisfy.

You were asked some questions about the timing and Mr Leck was cross-examined in May, then he had an interview in the middle of June, and we are now talking the beginning of October. What's your opinion of the progression of this medical illness?-- Well, it is my understanding that his condition has exacerbated or gotten worse, if you want to put it that way, since then, and that's often how depression goes. If there's some ongoing external stressor, which is his worries and concerns about appearing before the Commission of Inquiry, then it is not unexpected that he would have a worsening of his condition.

And that's really what you observed, a worsening of his condition - that's your opinion?-- Well, yes, it's certainly, from what I've read, and from taking a history from him, it is my opinion that there has been a deterioration in terms of the severity of his condition.

All right?-- He's not as severe that he needs to go into

hospital, I'm not trying to say that, but it is reaching a point where he's having quite some difficulties that I have already outlined.

I'm reminded the question you have answered - you have used the word "temporary" on a number of occasions?-- Mmm.

And I think you explained that "temporary" could mean a short period of time or a long period of time?-- Yes.

What's the sort of - what's the range - what sort of range are we talking about?-- Well - yeah, well, that's a very difficult question. All I can say is it would be something that may go from a few months to a year, something like that. I couldn't really - I don't believe anyone could predict that with any more accuracy than that, but I don't anticipate that in the longer term it would lead to a severe exacerbation that didn't recover, but I'm saying it would be temporary. But, of course, with someone who is depressed like this, with suicidal ideation, you always have to worry in the short term an exacerbation of someone who has this level of disorder could be a significant decompensation.

COMMISSIONER: But you say it could be a few months to a few years?-- No, no, to one year, Commissioner.

To one year?-- Mmm.

Thank you. That is if he gave evidence - that is the effect, you say, of giving evidence, say, in this Commission?-- Well, I'm just saying it is a very difficult thing to answer.

I understand that. But that's the best answer you can give?-- It is the best answer I can give. There's no scientific evidence that will tell us - we can't measure that. We can only go by clinical experience.

You have told us that the effect on him of having - giving evidence in a more benign environment would have a less severe effect on him?-- Yes.

The prospect then of his recovering from that effect sooner would be greater if that took place?-- Yes, I would say, in general terms, that would apply.

It would be more likely to be a few months rather than a year?-- Well, yes, he would be more likely to have a shorter term one if it was not as stressful for him.

Thank you.

MR FREEBURN: Does the less stressful environment that - affect the degree of possible harm and the likelihood of that harm? Does that question make - I will rephrase that. You are saying that if he gave evidence in a less threatening environment - in a more benign environment - the prospect of harm to him is lessened; is that right?-- Yes. The prospect of harm to him would be lessened by giving evidence in a less

stressful or threatening environment.

But is still present?-- It would still be present. There still is a risk of harm.

And assessing that risk, there's at least some sort of significant risk of harm?-- Well, it is significant in the sense that he already has a level of depression and anxiety that's fairly difficult to treat for his - I can see for his treating psychiatrist. I mean, he is not really treating a remission of symptoms as being some slight lessening of some symptoms with treatment, such as sleep is a little better. He still has a disturbance. There is still a risk even from a minimal stimulation.

Thank you.

COMMISSIONER: Just one thing arising out of that, doctor: would it be correct that in whatever environment he gives evidence, if he gave evidence, the termination of the inquiry would be likely to lead to a lessening of his condition?-- I think that there would be certainly - once the stressor of having to appear any further at an inquiry is gone, that would certainly be beneficial for him, but it might take - it is a bit like a delayed reaction. Sometimes patients suffering anxiety and depression take quite a while to recover, when the average person who is anxious about giving evidence recovers quite quickly. It is really - to use the analogy of a bad back, it is a bit like that. If you have got a bad back to start with and you lift something heavy, it might take a long time to settle, as opposed to someone who doesn't have that.

So, the termination of his having to give evidence would have some beneficial effect on him sooner or later?-- I would say definitely sooner or later.

After he gave evidence, the Commission would make findings and recommendations, some of which may be to his detriment. Would getting the whole thing out of the road, for example, make some - have some beneficial effect on his condition - the fact it is all over and finally dealt with?-- Well, he has expressed quite openly to me that he wanted to get the whole thing over and done with. I mean, I think anyone who is very worried about something like a Commission such as this, in the end, once it is all over and the findings are out, I think, yes, there would be some lessening of the pressure or the stressor of that, but I suppose if there's adverse findings, and one is still anxious and depressed, the anxiety and depression may continue on for quite a while. It is very difficult to say. I don't know what the - I don't know. There's a lot of different scenarios there - ways that could go.

Thank you. Anything further, Mr Andrews?

MR ANDREWS: One last matter, Commissioner.

RE-EXAMINATION:

MR ANDREWS: Am I right to conclude that if Mr Leck is to give evidence, one of - one substantial way of minimising the anxiety for him and any danger to him would be if he were able to give as much of that evidence as possible in a written statement obtained from him by his lawyers?-- Oh, I would say that would be the less - the least stressful situation, yes.

Thank you. I have nothing further, Commissioner.

COMMISSIONER: Thank you. You are excused from further attendance, doctor. Thank you for coming?-- Thank you.

WITNESS EXCUSED

COMMISSIONER: Do you want to make - I assume you are pursuing your application that Mr Leck not give evidence?

MR FREEBURN: Yes.

COMMISSIONER: Do you want to add to the submissions contained in your solicitor's letter?

MR FREEBURN: We think - we would say that we might be able to provide the Commission with a fair deal of assistance once we went through the transcript of the doctor's evidence, and we would like to make some submissions pointing to some of the remarks that the doctor has made.

COMMISSIONER: All right. I will give you that opportunity. In that event, perhaps you would give them in writing, then.

MR FREEBURN: Yes.

COMMISSIONER: That will save the appearing time of this Commission.

MR FREEBURN: Yes.

COMMISSIONER: Do you want to make any submissions on that?

MR MULLINS: I do.

COMMISSIONER: Anyone else?

MR DIEHM: Yes, I may wish to make a brief submission also.

COMMISSIONER: Yes.

MR ALLEN: I may wish to be heard, depending on whether or not

my learned friend Mr Mullins covers everything.

COMMISSIONER: Yes.

MR ANDREWS: Commissioner, I may wish to be heard, too, but one matter that would be of practical benefit in determining what submissions would be made would be to know whether Mr Leck's lawyers propose to give a comprehensive statement from Mr Leck or whether they do not.

COMMISSIONER: Mr Freeburn?

MR FREEBURN: There's no signed statement, so we will take some instructions about that.

COMMISSIONER: There's absolutely no reason why he couldn't provide a statement, is there?

MR FREEBURN: Well, my solicitor is having some difficulty getting the detail out of Mr Leck.

COMMISSIONER: Mmm. Well, there's no reason why he can't provide some sort of statement, as best can be achieved, surely. It might require a little longer with him than it might with other people, but I can't see why it is impossible. Anyway, you will certainly do your best to produce a statement and, given the time you have had up to now, I can't see any reason why it couldn't be produced, say, within two days. You don't disagree with that, surely.

MR FREEBURN: Well, I need to take some instructions about that.

COMMISSIONER: I'm not making any order about this, but I would expect that if you are going to provide a statement, you would do that within two days or provide some explanation to the Commission as to why that couldn't reasonably be done, given that you have had - not you personally, but your solicitors have had a very long time to provide a statement from Mr Leck to the Commission. Now, your submission is in writing. Can you provide those by the end of Court time tomorrow?

MR FREEBURN: Yes.

COMMISSIONER: I direct you provide submissions in writing to the Commission by 4.30 tomorrow and to provide copies of those submissions to all other counsel appearing in this inquiry, and I therefore direct that any other submissions that any other counsel wants to make to this inquiry, other than counsel assisting the Commission, make those within 24 hours of receipt of your submissions. Anyone have any objection to that? Anyone think they reasonably need further time?

MR DIEHM: No, Commissioner.

COMMISSIONER: All right. I give those directions accordingly. There is nothing further, is there - except to

tell us about tomorrow, if you can.

MR ANDREWS: I know that Dr Sam Baker is the witness for 10 a.m.. I'm optimistic that a witness will be obtained, or more, with respect to measured quality, but I can't confirm it yet. I understand that it had to do with a witness being available.

COMMISSIONER: Well, we will endeavour to do that by the end of today. All right, we will adjourn.

THE COMMISSION ADJOURNED AT 3.49 P.M. TILL 10 A.M. THE FOLLOWING DAY